My appointment to apply for Social Security Disability was on December 1, 2015 at 11:02am in San Fernando. I was not late, I was on time. I waited about 10-15 mins.

I was seen by Mr. Landini, a young guy. I gave him my information verbally while sitting at his desk and he appeared to be inputting it into his computer. I gave him all the information he asked for including my bank account information. I explained to Mr. Landini why I was there. I was the victim of hate crimes and had PTSDs from the hate crimes and the pain and trauma reinforced by the FBI/DOJ/LAPD and what made it worse was I was coming forward to sexual abuse and hate crimes that happened in 1998 and I put up a website with my story, ScientologyForYou.info. When I went into details, he laughed at me, he thought it was funny. I did not find it funny and didn't know what to say. I found it weird, that an employee of SSA was laughing at me after finding out what happened to me. This was abuse by Mr. Landini, verbal and emotional.

I also told him I just got the full psych files from Olive View and found out that I was sexually abused in the hospital while unconscious. I went from 2 back to back sexual abuse incidents, one in my home and one in the hospital in 1998. Again he thought it was funny. I didn't think it was funny. I felt abused.

I gave Mr. Landini my bank account information, I never said I didn't have one, I was told I had to give him that information to complete the application. I remember that cause I asked him why couldn't they send a check and he said it was all direct deposit and after you are approved every month, they just deposit the money into your account and it's very convenient even if you move out of state and that's when I asked about that cause in California Disability, if you

move out of California you lose it. We then talked about how the cost of living is lower in other states and I asked what the amount of my disability would be and he said around $1317.00 per month.

I was sent a letter dated November 23, 2015 about my appointment and in that letter it said what to bring with me, what they would need for my application. I brought my tax returns for the past 2 years and my checkbook.

I also brought medical records with me, he never made copies of what I brought, he only took the 1st portion of the Orthopedic Medical Center records which was 6 pages, he didn't make copies of the 2nd portion. This was a car accident, I was re ended and I was never able to finish my physical therapy cause the insurance company refused to pay out which was against the law and the Judge refused to award me the full amount so that I could pay that money to finish my physical therapy. I also had other medical records that I brought with me, he said he didn't need them and they had ways to get them on their own. He never made copies of those.

I left around noon, I remember cause their clock on the wall was 12:00 and I pointed that out to him cause don’t they take a lunch? Most offices and office workers take lunch at 12:00 noon. I can’t remember his response.

For my hearing on 3/20/2018 I was sent evidence on a CD, when I went thru it I found Mr. Landini had committed crimes.

False information on the Application Summary For Disability Insurance Benefits

#1 - I have never used the name Katalin Sutta, my mother did when I was little and I don't know where he got that information from.

#2- I became unable to work on 11/28/2013 – I gave him 11/26/2013, this information was given to Mr. Landini.
This was a mistake on my part, after reviewing my records on 2/21/2018 it was 11/28/2013

My last wage job was on 6/28/2013 and my last independent contractor job was on 11/28/2013.

#3 - The social security administration had permission to contact past employers. I had no current employer to contact.

#4 - I was married in 1987 and got divorced in 1988/1989.

#5 - I have a bank account. I gave Mr. Landini my bank account information, I do not know if he stole my bank account information.

#6 - I had posted earnings for 1986 .

The time listed on my receipt is false. It's 14:32 which is military time and that translated to 2:32pm. I did not spend 3 1/2 hours in that office with Mr. Landini. Nor wait 3 hours to be seen. I spent about 20 mins talking to Mr. Landini about my scene and why I was applying. I left around 12:00 noon.

I think the clock on his computer was off unless he changed the time on his computer himself on purpose.

I never gave Mr. Landini any information about Olive View so I don't know how they tried to get a report/reports but the less then 40 pages of the psych report from 1998 is on my ScientologyForYou.info website that's not public, publicly displayed, you have to dig for it. The dates 1998 and 2008 are also listed on

my ScientologyForYou.info website. I never gave him any information about being in Olive View in 2008, that information is listed on ScientologyForYou.info

The psych reports from 1998 and 2008 are not relevant to me applying for disability but they are relevant in my Federal Lawsuit against the FBI/DOJ/LAPD as well as my other Federal Lawsuit against the LAPD/OliveViewMedical/ChurchOfScientology. Mr. Landini knew I was in the process of going to Federal Court, cause I explained it to him.

Mr. Landini's action's didn't help my case, it hurt, harmed my case and prevented me from getting disability. 2 years of my life wasted because of the false information put into the computer by Mr. Landini. That's 2 years of continuing to borrow money to survive, financial hardship.

I don't know all the reasons Mr. Landini wrote false information on my application so that I would not receive disability benefits. My guess is cause I'm a Scientologist, Jewish, Catholic, a woman, my age, my ethnicity etc etc. All counts. He was fully aware that I was borrowing money to survive and I'm currently on food stamps. Without borrowing money, I would be homeless from the hate crimes committed on me that completely destroyed my life.

Constitution and Laws Broken By Mr. Landini – SSA Employee

Constitution

1st , 4th, 5th, 9th and 14th amendment

Federal Laws

Title II of the Civil Rights Act of 1964 – prohibits discrimination because of race, color, religion, or national origin in certain places of public accommodation.

42 U.S. Code § 2000a - Prohibition against discrimination or segregation in places of public accommodation

42 U.S. Code § 12131 - Definitions

42 U.S. Code § 12181 - Definitions

18 U.S.C. § 1621 - U.S. Code - Unannotated Title 18. Crimes and Criminal Procedure § 1621. Perjury generally

(2) in any declaration, certificate, verification, or statement under penalty of perjury as permitted under section 1746 of title 28, United States Code, willfully subscribes as true any material matter which he does not believe to be true;

28 U.S. Code § 1746 - Unsworn declarations under penalty of perjury

(2) If executed within the United States, its territories, possessions, or commonwealths: “I declare (or certify, verify, or state) under

penalty of perjury that the foregoing is true and correct. Executed on (date).

8 U.S. Code § 1324c - Penalties for document fraud

(5)
to prepare, file, or assist another in preparing or filing, any application for benefits under this chapter, or any document required under this chapter, or any document submitted in connection with such application or document, with knowledge or in reckless disregard of the fact that such application or document was falsely made or, in whole or in part, does not relate to the person on whose behalf it was or is being submitted, or

(f)FALSELY MAKE

For purposes of this section, the term "falsely make" means to prepare or provide an application or document, with knowledge or in reckless disregard of the fact that the application or document contains a false, fictitious, or fraudulent statement or material representation, or has no basis in law or fact, or otherwise fails to state a fact which is material to the purpose for which it was submitted.

18 U.S. Code § 2261A – Stalking

(B)

causes, attempts to cause, or would be reasonably expected to cause substantial emotional distress to a person described in clause (i), (ii), or (iii) of paragraph (1)(A),

Intentional infliction of emotional distress

California State Laws

Unruh Civil Rights Act 3067. Unruh Civil Rights Act—Damages (Civ. Code, §§ 51, 52(a)

California Penal Code Section 115 PC

(a) Every person who knowingly procures or offers any false or forged instrument to be filed, registered, or recorded in any public office within this state, which instrument, if genuine, might be filed, registered, or recorded under any law of this state or of the United States, is guilty of a felony.

California Penal Code 646.9 PC

(a) Any person who willfully, maliciously, and repeatedly follows or willfully and maliciously harasses another person and who makes a credible threat with the intent to place that person in reasonable fear for his or her safety, or the safety of his or her immediate family is guilty of the crime of stalking, punishable by imprisonment in a county jail for not more than one year, or by a fine of not more than one thousand dollars ($1,000), or by both that fine and imprisonment, or by imprisonment in the state prison.

Exhibit A

1D.pdf – *the application Mr. Landini filled out in the computer.*
ReceivedFromSSAOffice12-1-2015.pdf
SentFromSSAOffice.pdf
Records12-1-2015A.pdf
Records12-1-2015B.pdf
Records12-1-2015C.pdf

Medical Records/Court Case I brought with me that Mr. Landini rejected

Exhibit B

2D.pdf – *Mr. Landini updated my SSA records/application at 14:55, I had already left per their internal computer clock at 14:32. Evidence that Mr. Landini wrote down my information including my bank account information that he wrote I didn't have and*

ScientologyForYou.info website.
ReceivedFromSSAOffice12-1-2015.pdf

Exhibit C
1E.pdf
ReceivedFromSSAOffice12-1-2015.pdf

Exhibit D

2E.pdf
ReceivedFromSSAOffice12-1-2015.pdf

Exhibit E

KathyGoldScientology.pdf
LessThen40PagePsychReport1998.pdf
ScientologyForYou.pdf

Exhibit F
3D.pdf
DetailedEarningsQuerySSA.pdf

The time on this document is false, I did not leave that office at 2:32pm I left the SSA field office at around 12:00 noon

[redacted]

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Exhibit A - Landini

UNIT: RS6DIB

KATHLEEN MARIE GOLD
11100 SEPULVEDA BLVD
NO 512
MISSION HILLS CA 91345

APPLICATION SUMMARY FOR DISABILITY INSURANCE BENEFITS

On December 1, 2015, we talked with you and completed your application for SOCIAL SECURITY BENEFITS. We stored this information electronically in our records. We are enclosing a summary of your statements.

I APPLY FOR A PERIOD OF DISABILITY AND/OR ALL INSURANCE BENEFITS FOR WHICH I AM ELIGIBLE UNDER TITLE II AND PART A OF TITLE XVIII OF THE SOCIAL SECURITY ACT, AS PRESENTLY AMENDED.

MY NAME IS KATHLEEN MARIE GOLD.

#1 I HAVE USED THE FOLLOWING NAME(S):
KATALIN SUTTA This is false
KATHY SUTTA

[redacted]

MY DATE OF BIRTH IS December 17, 1966.

I AM A CITIZEN OF THE UNITED STATES.

#2 I BECAME UNABLE TO WORK BECAUSE OF MY DISABLING CONDITION ON August 15, 2015. This is false

I AM STILL DISABLED.

NO PREVIOUS APPLICATION HAS BEEN FILED WITH THE SOCIAL SECURITY ADMINISTRATION BY OR FOR ME.

I DO NOT WANT TO FILE FOR SSI.

I HAVE NOT FILED NOR DO I INTEND TO FILE FOR ANY WORKERS' COMPENSATION, PUBLIC DISABILITY OR BLACK LUNG BENEFITS.

I AM NOT ENTITLED TO NOR DO I EXPECT TO BECOME ENTITLED TO A PENSION OR ANNUITY BASED IN WHOLE OR IN PART ON WORK AFTER 1956 NOT COVERED BY SOCIAL SECURITY.

THE SOCIAL SECURITY ADMINISTRATION AND THE STATE AGENCY REVIEWING MY CLAIM DO

[redacted]

SG-SSA-16

#3 NOT HAVE MY PERMISSION TO CONTACT MY EMPLOYER(S). This is false, I have no employer to contact

This is false **#4** I NEVER MARRIED OR I HAD NO PREVIOUS MARRIAGES THAT LASTED 10 YEARS OR MORE OR ENDED IN DEATH.

I DO NOT HAVE ANY CHILDREN UNDER AGE 18; AGE 18-19 ATTENDING ELEMENTARY OR SECONDARY SCHOOL FULL TIME; OR AGE 18 OR OVER AND DISABLED BEFORE AGE 22 WHO MAY BE ELIGIBLE FOR SOCIAL SECURITY BENEFITS ON THIS RECORD. THIS INCLUDES CHILDREN WHO MAY OR MAY NOT BE LIVING WITH ME.

#5 I DO NOT HAVE A BANK ACCOUNT. This is false

REMARKS:

#6 MY EARNINGS RECORD IS CORRECT AS POSTED. I HAD NO POSTED COVERED EARNINGS IN THE YEARS 1986,2009. This is false

I REALIZE RECEIPT OF ANY ADDITIONAL DISABILITY BENEFITS MAY RESULT IN A REDUCTION OF MY DISABILITY INSURANCE BENEFITS, THUS I WILL REPORT OTHER BENEFITS RECEIVED TO PREVENT ANY OVERPAYMENTS.

I KNOW THAT ANYONE WHO MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF MATERIAL FACT IN AN APPLICATION OR FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW BY FINE, IMPRISONMENT OR BOTH. I AFFIRM THAT ALL INFORMATION I HAVE GIVEN IN CONNECTION WITH THIS CLAIM IS TRUE.

This D.Landini falsely inputted this information into the computer, I gave him my checking account number, he wrote that I had no bank account. I suspect he stole my person information and my bank account information.

MY TELEPHONE NUMBER IS (818) 235-6370.

The time on this receipt is military time which translates to 2:32pm but this is false as I left around 12:00pm noon.

December 1, 2015, 14:32
PAGE 1

[redacted]

SG-SSA-16

SOCIAL SECURITY ADMINISTRATION
IMPORTANT INFORMATION

RECEIPT FOR YOUR CLAIM FOR SOCIAL SECURITY DISABILITY INSURANCE BENEFITS

Exhibit A, B, C, D - Landini

KATHLEEN MARIE GOLD
11100 SEPULVEDA BLVD
NO 512
MISSION HILLS CA 91345

YOUR APPLICATION FOR SOCIAL SECURITY BENEFITS HAS BEEN RECEIVED AND WILL BE PROCESSED AS QUICKLY AS POSSIBLE.

The number of days is blank

YOU SHOULD HEAR FROM US WITHIN __ DAYS AFTER YOU HAVE GIVEN US ALL THE INFORMATION WE REQUESTED. SOME CLAIMS MAY TAKE LONGER IF ADDITIONAL INFORMATION IS NEEDED.

IN THE MEANTIME, IF YOU CHANGE YOUR ADDRESS, OR IF THERE IS SOME OTHER CHANGE THAT MAY AFFECT YOUR CLAIM, YOU - OR SOMEONE FOR YOU - SHOULD REPORT THE CHANGE.

We are providing the attached application for your records.

We stored your application information electronically so there is no reason for us to retain a paper copy of your application.

IMPORTANT REMINDER

Penalty of Perjury **I didn't fill out this application, Mr. Landini did, he violated the Penalty of Perjury.**

You declared under penalty of perjury that you examined all the information on this form and it is true and correct to the best of your knowledge. You were told that you could be liable under law for providing false information.

THE TELEPHONE NUMBERS TO CALL IF YOU HAVE A QUESTION OR SOMETHING TO REPORT ARE:

BEFORE YOU RECEIVE A NOTICE ABOUT YOUR CLAIM: **This is blank**

AFTER YOU RECEIVE A NOTICE ABOUT YOUR CLAIM: **This is blank**

SOCIAL SECURITY INFORMATION IS ALSO AVAILABLE TO INTERNET USERS AT WWW.SOCIALSECURITY.GOV.

What You Need To Do

- Review the summary to make sure we recorded your statements correctly.
- If you agree with all your statements, you may keep the information for

There was no summary given to me with this receipt, all I got was this receipt.

The time on this receipt is military time which translates to 2:32pm but this is false as I left around 12:00pm noon.

your records.

- If you disagree with any of your statements, please contact us within 10 days after receiving this notice to let us know.

ALWAYS GIVE US YOUR CLAIM NUMBER WHEN WRITING OR TELEPHONING ABOUT YOUR CLAIM. IF YOU HAVE ANY QUESTIONS ABOUT YOUR CLAIM, WE WILL BE GLAD TO HELP YOU.

WE ARE RETURNING ANY DOCUMENT(S) YOU MAY HAVE SUBMITTED WITH YOUR APPLICATION.

HELPFUL HEALTH CARE WEBSITES

Health Information

The U.S. Department of Health and Human Services provides information on many health topics at www.healthfinder.gov on the Internet. You may wish to visit that site to review that information, which may be helpful to you.

Prescription Drug Assistance Programs

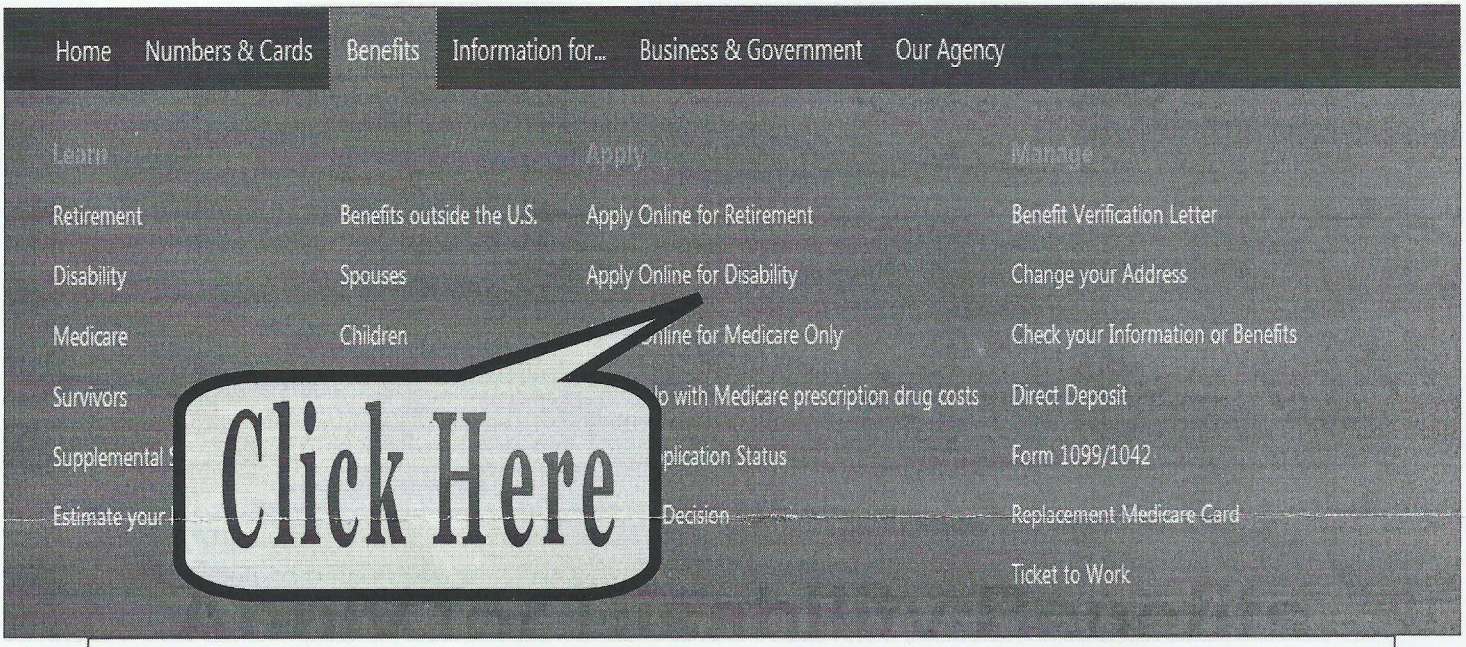
You may be able to get help paying for prescription drugs. To find out what programs are offered by drug companies, state and local governments, and local organizations, please visit www.healthfinder.gov/rxdrug on the Internet.

CLAIMANT
KATHLEEN M GOLD [redacted]

This is page 1 of what I received while waiting for my appointment

Apply for Disability Benefits

at www.socialsecurity.gov



Social Security offers an online disability application you can complete at your convenience. Apply from the comfort of your home or any location at a time most convenient for you. You do not need to drive to your local Social Security office or wait for an appointment with a Social Security representative.

> Who can apply for adult disability benefits online?

> How do I apply for benefits?

> What information do I need to apply for benefits?

> What documents do I need to provide?

> What are the advantages of applying using our online disability application process?

> What happens after I apply?

> What other ways can I apply?

Note

Select "Return to a Saved Application" if before January 25, 2014, you started but did not finish:

- An Application for Disability Benefits and have an "Application Number;" or
- An "Adult Disability Report" and have a "Reentry Number."

Once you enter your "Application Number" or "Reentry Number" and your Social Security Number, you will return to your saved information.

Apply for Disability | Return to a Saved Application | Check Applicaton Status

Click on "Apply for Disability" to start your application.

This is page 2 of what I received while waiting for my appointment

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN — —	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):
OF WHAT *All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY	**IF not signed by subject of disclosure, specify basis for authority to sign**
INDIVIDUAL authorizing disclosure	☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**
SIGN ▶	(Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP —

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

This is page 3 of what I received while waiting for my appointment

Explanation of Form SSA-827, "Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your claim, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A covered entity (that is, a source of medical information about you) may not condition treatment, payment, enrollment, or eligibility for benefits on whether you sign this authorization form. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. SSA may use information disclosed prior to revocation to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA-827 is provided to you in your native or preferred language.

Privacy Act Statement
Collection and Use of Personal Information

Sections 205(a), 233(d)(5)(A), 1614(a)(3)(H)(i), 1631(d)(l) and 1631(e)(l)(A) of the Social Security Act as amended, [42 U.S.C. 405(a), 433(d)(5)(A), 1382c(a)(3)(H)(i), 1383(d)(l) and 1383(e)(l)(A)] authorize us to collect this information. We will use the information you provide to help us determine your eligibility, or continuing eligibility for benefits, and your ability to manage any benefits received. The information you provide is voluntary. However, failure to provide the requested information may prevent us from making an accurate and timely decision on your claim, and could result in denial or loss of benefits.

We rarely use the information you provide on this form for any purpose other than for the reasons explained above. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist us in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from our records (e.g., to the Government Accountability Office, General Services Administration, National Archives Records Administration, and the Department of Veterans Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of our programs (e.g., to the U.S. Census Bureau and to private entities under contract with us).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave us is available in our Privacy Act Systems of Records Notices entitled, Claims Folder System, 60-0089; Master Beneficiary Record, 60-0090; Supplemental Security Income record and Special Veterans benefits, 60-0103; and Electronic Disability (eDIB) Claims File, 60-0340. The notices, additional information regarding this form, and information regarding our systems and programs, are available on-line at www.socialsecurity.gov or at any Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE.** You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory **or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

GPO U.S. GOVERNMENT PRINTING OFFICE: 2015—388-031

DISABILITY REPORT - ADULT
SSA-3368-BK

PLEASE READ THIS INFORMATION BEFORE COMPLETING THIS REPORT

The information you give us on this report will be used by the office that makes the disability decision on your disability claim. Completing this report accurately and completely will help us expedite your claim. Please complete as much of the report as you can.

IF YOU NEED HELP

You can get help from other people, such as a friend or family member. Please do **not** ask your health care provider to complete this report. If you cannot complete the report, a Social Security Representative will assist you. If you have an appointment, please have the completed report ready when we contact you. If we ask you to do so, please mail the completed report to us ahead of time.

Note: If you are assisting someone else with this report, please answer the questions as if that person were completing the report.

HOW TO COMPLETE THIS REPORT

- Print or write clearly.
- Include a ZIP or postal code with each address.
- Provide complete phone numbers including area code. If a phone number is outside the United States, also provide International Direct Dialing (IDD) code and country code.
- If you cannot remember the names and addresses of your health care providers, you may be able to get that information from the telephone book, Internet, medical bills, prescriptions, or prescription medicine containers.
- **ANSWER EVERY QUESTION,** unless the report indicates otherwise. If you do not know an answer, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any question, please use Section 11 - Remarks on the last page to finish your answer. Write the number of the question you are answering.

YOUR MEDICAL RECORDS

If you have any of your medical records, send or bring them to our office with this completed report. Please tell us if you want to keep your records so we can return them to you. If you are having an interview in our office, bring your medical records, your prescription medicine containers (if available), and the completed report with you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will request your records. The information that you give us on this report tells us where to request your medical and other records.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or is expected to result in death. So when we ask "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

Privacy Act Statement
Collection and Use of Personal Information

Section 205(a), 223(d), and 1631(e)(1) of the Social Security Act, as amended, authorize us to collect this information. We will use the information you provide to make a decision on the named claimant's claim.

Furnishing us this information is voluntary. However, failing to provide us with all or part of the information could prevent us from making an accurate and timely decision on the named claimant's claim.

We rarely use the information you supply for any purpose other than to make decisions regarding claims. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;

2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);

3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,

4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you provide in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. Information from these matching programs can be used to establish or verify a person's eligibility for federally-funded or administered benefit programs and for repayment of payments or delinquent debts under these programs.

A complete list of routine uses for this information is available in Systems of Records Notice entitled, Claims Folders Systems, 60-0089. This notice, additional information regarding this form, and information regarding our programs and systems, are available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 60 minutes to read the instructions, gather the facts, and answer the questions.

SEND OR BRING THE COMPLETED FORM TO THE OFFICE THAT REQUESTED IT. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778). *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

AFTER COMPLETING THIS REPORT, REMOVE THIS SHEET AND KEEP IT FOR YOUR RECORDS

This is page 6 of what I received while waiting for my appointment

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only- Do not write in this box.

Related SSN _____

Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last)

1.B. Social Security Number

1.C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

1.D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number _____

☐ Check this box if you do not have a phone or a number where we can leave a message .

1.F. Alternate Phone Number - another number where we may reach you, if any.

Alternate phone number _____

1.G. Can you speak and understand English? ☐ Yes ☐ No

If no, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? ☐ Yes ☐ No

1.I. Can you write more than your name in English? ☐ Yes ☐ No

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☐ Yes ☐ No

If yes, please list them here: _____

SECTION 2 - CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)

2.B. Relationship to you

2.C. Daytime Phone Number (as described in 1.E. above)

2.D. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

2.E. Can this person speak and understand English? ☐ Yes ☐ No

If no, what language is preferred? _____

This is page 7 of what I received while waiting for my appointment

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- ☐ The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- ☐ The person listed in 2.A. (Go to Section 3 - Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)	**2.H.** Relationship to Person Applying

2.I. Daytime Phone Number _____

2.J. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA

SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability
If you have cancer, please include the stage and type. List each condition separately.

1.
2.
3.
4.
5.

If you need more space, go to Section 11-Remarks on the last page

3.B. What is your height without shoes? ____ feet ____ inches OR _____ centimeters (if outside USA)

3.C. What is your weight without shoes? _____ pounds OR _____ kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? ☐ Yes ☐ No

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☐ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though yo never worked)? (month/day/year) _____ (Go to Section 5 on page 3)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) _____

Why did you stop working?

- ☐ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed)

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year) _____

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- ☐ No (Go to Section 5 - Education and Training on page 3)
- ☐ Yes When did you make changes? (month/day/year) _____

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5) ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No When did your condition(s) first start bothering you? (month/day/year) _____

☐ Yes When did you make changes? (month/day/year) _____

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No ☐ Yes

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed.

0	1	2	3	4	5	6	7	8	9	10	11	12	GED	College: 1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date completed: _____

5.B. Did you attend special education classes? ☐ Yes ☐ No (Go to 5.C.)

Name of School _____

City _____ State/Province _____ Country (If not USA) _____

Dates attended special education classes: from _____ to _____

5.C. Have you completed any type of specialized job training, trade, or vocational school? ☐ Yes ☐ No

If "Yes," what type? _____ Date completed: _____

If you need to list other education or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
		From MM/YY	To MM/YY			Amount	Frequency
1.							
2.							
3.							
4.							
5.							

SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day?

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. In this job, did you:

Use machines, tools or equipment? ☐ Yes ☐ No

Use technical knowledge or skills? ☐ Yes ☐ No

Do any writing, complete reports, or perform any duties like this? ☐ Yes ☐ No

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop *(Bend down & forward at waist.)*		Handle large objects	
Stand		Kneel *(Bend legs to rest on knees.)*		Write, type, or handle small objects	
Sit		Crouch *(Bend legs & back down & forward.)*		Reach	
Climb		Crawl *(Move on hands & knees.)*			

6.E. Lifting and carrying *(Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.)*

6.F. Check **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

6.G. Check weight **frequently** lifted: *(by frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

6.H. Did you supervise other people in this job? ☐ Yes (Complete items below.) ☐ No (if No, go to **6.I.**)

How many people did you supervise? _____

What part of your time did you spend supervising people? _____

Did you hire and fire employees? ☐ Yes ☐ No

6.I. Were you a lead worker? ☐ Yes ☐ No

SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ Yes (Give the information requested below. You may need to look at your medicine containers.)

☐ No (Go to Section 8-Medical Treatment.)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled**?

8.A. For any **physical** condition(s)?

☐ Yes ☐ No

8.B. For any **mental** condition(s) **(including emotional or learning problems)**?

☐ Yes ☐ No

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please gi the dates for past and future tests. If you need to list more tests, use Section 11-Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	**Dates of Tests**	**Kind of Test**	**Dates of Tests**
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.D. Name of Facility or Office	Name of health care professional who treated you

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Phone Number	Patient ID# (if known)

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Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

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What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

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☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

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☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
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☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of health care professional who treated you
ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.	
Phone Number	Patient ID# (if known)
Mailing Address	

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first	
First Visit	A.	A. Date in	Date out
Last Visit	B.	B. Date in	Date out
Next scheduled appointment (if any)	C.	C. Date in	Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	**Dates of Tests**	**Kind of Test**	**Dates of Tests**
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ Yes (Please complete the information below.)

☐ No (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Name of Contact Person	Claim or ID number (if any)

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. Have you participated, or are you participating in:

- An individual work plan with an employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ Yes (Complete the following information) ☐ No (Go to Section 11)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

10.C. When did you start participating in the plan or program?

Gold, Kathy Female 12-17-1966

Exhibit A - Landini

Orthopedic Medical Center

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